

Oral Infinity Logo

**For patients who are seeking care from both Dr. Angie Tenholder of Synergy Dental Solutions and Nicole Edwin of Oral Infinity, we require that you read, understand, and sign or initial the following:**

State law requires that it be clearly explained that both Dr. Tenholder and Nicole Edwin will be assessing and treating patients in the same facility located at 1000 Eleven South Suite 3F Columbia, Illinois. Both providers are licensed professionals and functioning under their respective practice acts.

\_\_\_\_Initial

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*Synergy Dental Solutions, PC Informed Consent for Treatment:*

State Law requires us to obtain your consent for any contemplated treatment. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you don't understand. We will be pleased to explain it.

I hereby authorize and direct Angela Tenholder DMD assisted by other dental auxiliaries of her choice to perform upon myself, my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by Dr. Tenholder in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

\_\_\_ Initial

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*Oral Infinity Informed Consent for Treatment*

State Law requires us to obtain your consent for any contemplated treatment. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you don't understand. We will be pleased to explain it.

I hereby authorize and direct Nicole Edwin MS, CCC-SLP, CLC, to perform upon myself, my child (or legal ward) a complete oral functional examination including diagnostic aids deemed necessary in order to properly assess the condition of my child. I also understand that if therapy is recommended, I will be required to sign consent for therapy after having been explained the proposed treatment.

\_\_\_ Initial

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*Joint Provider Informed Consent Agreement*

I understand that there will be times that Nicole Edwin will be acting as Speech and Language Pathologist under her Illinois State license and at times she will be functioning as a dental assistant under the license of Dr. Angela Tenholder. Every effort will be taken to clearly communicate this separation of professional licensing and scope of practice including and especially:

1. Scheduling during separate times of day or days of the week
2. Designation of Nicole as a dental assistant by the wearing of the uniform lab coat worn by other dental assistants working for Dr. Tenholder
3. Verbal notification defining professional responsibility during every encounter
4. Payment for services provided will be made directly to Nicole Edwin for services provided under her license as a Speech and Language Pathologist and made payable to her corporation Oral Infinity/MyNeoNourish, LLC
5. Payment for services provided will be made directly to Synergy Dental Solutions for services performed under Dr. Tenholder’s license
6. If laser therapy is being performed, Nicole is functioning under the license of Dr. Tenholder as a dental assistant performing legally delegatable duties as allowed under the Illinois Dental Practice Act

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedure have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my/my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_